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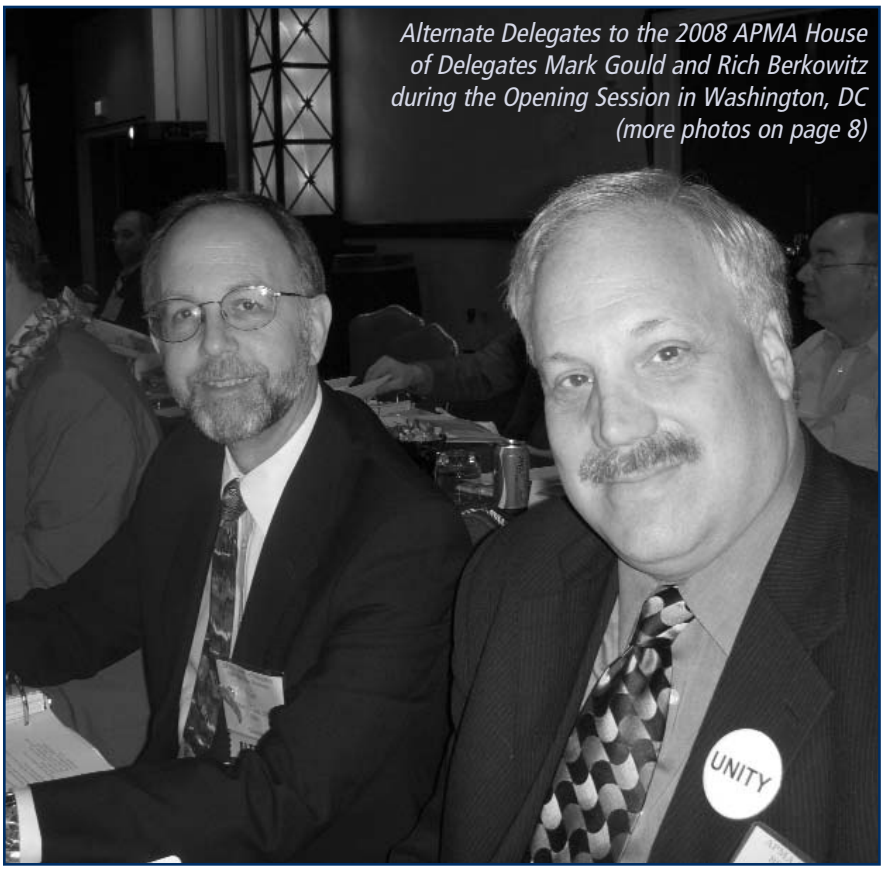

Alternate Delegates to the 2008 APMA House of Delegates Mark Gould and Rich Berkowitz during the Opening Session in Washington, DC (more photos on page 8)

National Membership Campaign to be Rolled Out Across Ohio

The Ohio Podiatric Medical Association will participate in the 2008-2009 APMA Member Recruitment Campaign for the upcoming fiscal year. The goal of the APMA's recruitment campaign is to increase membership in the APMA to 85 percent of all practicing podiatric physicians. Component societies of the APMA, such as the OPMA, are only allowed to participate in the Recruitment Campaign once every three years.

The membership drive will last for twelve months commencing on June 1, 2008 and ending on May 31, 2009. The recruitment drive is targeted at former and prospective members. Podiatric physicians who join during the 2008-2009 fiscal year will be given a 50% discount in national dues and a 20% discount in state dues. Discounts are not available to current members or members who resign or who are suspended during the campaign.

MEMBERSHIP continued on page 2

Ohio's Newest Insurance Contracting Law

On Tuesday, March 25, HB 125 was signed into Ohio law. This legislation was described by the Ohio State Medical Association, who advanced the legislation, as "one of the most sweeping physician-insurance industry contract reform bills in the nation." This legislation is intended to promote fairness and transparency in the contracting process, and a standard physician credentialing process. OPMA assisted in the lobbying efforts along with several other Health Care Provider Coalition of Ohio members.

James Holfinger, DPM, Chair of the OPMA Insurance Task Force rendered testimony in both House and Senate committees during the 15 hearing sessions that were held on the legislation. The legislation hosted more hearings than any piece of legislation submitted so far this session.

This new law is a huge step toward eliminating some of the more bureaucratic, unfair and anti-competitive practices that have been imposed on physicians by Ohio's HMOs and other health insurers. When this bill takes effect, there will be more bal

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In This Issue

President's Message

By Mark Gould, DPM

There is never a dull moment at OPMA. As long as I have been involved, things are always happening in Columbus and throughout the rest of the state.

Those who haven't read their e-mail or visited our great Web site lately should take note that House Bill 125 was signed into law by Governor Strickland on March 25th. This is a great accomplishment for the Association and the Provider Coalition for physicians in this state that should address a range of problems with insurance contracting. Kudos to our membership for their grass roots efforts. This is a good example of what can be achieved when we work together for a common goal. But the fight continues.

The OPMA 2006 House of Delegates enacted an Insurance Task Force "to investigate possible actions that can be taken to address discrimination by insurance companies against podiatrists in our state." The task force has met three times. The most recent Task Force meeting took place at the No-Nonsense CME seminar in Independence in March. I want to thank the North Central Academy for their hospitality and lunch. Our OPMA counsel, Nanci Danison, has been active in working to solve insurance fee disparity concerns without litigation. Should these attempts at working to arrive at a fair settlement fail, OPMA will be requesting our grass roots members to step up and take an active role again. This role will require our members not only to gather data and provide evidence to support this fight for equality, but if we do end up in litigation, we will be requesting additional money from each member to offset legal expenses. If we fail to generate convincing evidence or fall short of the funding required, our efforts will have been in vain. Therefore, I am urging each and every member to step up and send any and all information you have with respect to fee discrimination to the OPMA headquarters. Remember we are looking for factual data and not anecdotal information.

Our OPMA Delegation has just returned from Washington, D.C., from the APMA House of Delegates and Congressional visits where we are fighting other battles. Podiatrists are still attempting to be defined as physicians in Title XIX (Medicaid) as we are defined in Title XVIII (Medicare) and to correct the inequity of the DMEPOS competitive bidding ruling of CMS. Our two Ohio Senators, Sherrod Brown and George Voinovich, recognize the unfairness of the competitive bidding process for small businesses and initiated a bi-partisan letter to acting CMS administrator Kerry Weems expressing the Senate's concerns. A similar letter was created by the House and signed by a few Ohio Representatives. Although this doesn't directly address our concerns for dispensing durable medical equipment from our offices, it is a sign that some in Congress recognize the unfairness of this rule. The APMA's visits to Capitol Hill also emphasized the negative impact of the rule on our patients and our practices as small business owners and physicians.

On a brighter note, new membership applications to OPMA continue to come in and we are growing rather than losing membership. The larger we grow, the more representative we become, which will enable us to have a greater voice in the future of our profession. Thank you for your recruiting efforts and continue your good work.

Your OPMA staff has been working diligently to bring the Association a quality Region IV CME Scientific Seminar in June. I encourage all members to join us at the Columbus Hilton for a great meeting—socially and educationally. I look forward to seeing you there.

MEMBERSHIP continued from page 2

Podiatric physicians in full-time practice for more than four years can save $583.50 by taking advantage of this offer. In addition to the discounts offered, the APMA will also waive any past dues outstanding, even if the prospective member has used their one time dues waiver. The APMA is also allowing the OPMA to consider membership of those that are in financial hardship and may wish to apply for 5.4 Status (formerly referred to as hardship status). Ordinarily only members in good standing could apply for 5.4 Status.

The OPMA's goal is to add 40 new members to our ranks during the 2008-2009 fiscal year. The OPMA has approximately 540 current members, adding 40 new members would increase membership by about 7.5%. Unity within our profession has been a central reason why a small group such as the OPMA has been able to compete with larger medical associations in the healthcare arena. We are constantly faced with challenges from other medical associations, state legislatures, regulatory agencies, private health insurance companies and the federal government.

Please consider joining the OPMA and APMA during this recruitment campaign. The OPMA has ambitious plans to take an increasingly aggressive role in protecting and advancing the rights and privileges of podiatric physicians. We need the support of all podiatric physicians throughout Ohio to demonstrate the unity of purpose and the commitment of our professionals to step up and speak out for fair and equitable treatment.

From the Desk of the Executive Director

By Jimelle Rumberg, Ph.D., CAE

"No man's life, liberty or property is safe while the legislature is in session."

Mark Twain – 1866

Since the Ohio General Assembly is always "in session," legislative or regulatory happenings keep us on our toes at OPMA. In February, we addressed the Ohio Board of Dietetics regarding a rule change that would prohibit podiatrists from discussing nutritional concerns with patients; i.e., a referral to a licensed dietitian would have been necessary. Physicians were exempt; podiatric physicians were not.

I realize that sometimes professional nutritional counseling is necessary for many chronic disease states that affect patient care (diabetes, gout and edema) but felt strongly that each patient's treatment plan should be determined by the podiatric physician at the time the patient presents for care, not mandated by a rule change. Testimony was rendered and within a week, notice was received that the rule change was withdrawn.

Two weeks later, OPMA was addressing the Terminal Distributor License requirements with the State Pharmacy Board's executive director in tandem with the Health Care Provider Coalition. Their literal interpretation of the law states that incorporated physicians are business entities.

Needless to say, we feel that, as providers, the intent of the late-1990s legislation regarding incorporation wasn't meant to include providers in this manner. This is affecting practices ordering injectables (dentists, physicians and veterinarians) so we're actively engaged on working legislatively to correct this misinterpretation. Podiatric practices are not retail pharmacies and we're not dispensing drugs as retailers. Oddly enough, if your practice is not incorporated, this license isn't required. Although the "fix" will require corporation changes to the ORC to clarify and exempt physicians, dentists and veterinarians, I feel we will prevail.

Lastly, HB 355 on Medicaid Fraud is on our watch list. OPMA President, Mark Gould, wrote a salient letter stating our position to Representative Oelslager and his committee. In his letter, Dr. Gould stated that OPMA affirms the need to be vigilant to protect against fraud and abuse; however, HB 355 goes beyond the reasonable to the irrational.

> *Many podiatric physicians are at risk due to the complexities of medical coding and their need to rely upon others to interpret the coding requirement and constant modification to codes (bundling, modifiers, exclusions, etc.). As an association, we are steadfast in fighting health care fraud and abuse. OPMA is also cognizant that punitive measures need to be carefully tailored for those who perform intentional fraud. Providers should not be punished who are doing their best to submit claims consistent with inconsistent or unclear ODJFS and CMS governmental regulations and policies.*

The letter was well-received, and the legislation is in committee.

Guess you can surmise track season is upcoming and the legislative marathon continues, so let's lace up for a great run! Know I enjoy hearing from you by phone and mail, and I look forward to seeing you at the upcoming Region IV meeting in Columbus. It promises to be a great event and one you won't want to miss! See you soon!!!

Suppan Selected to State Medical Board of Ohio

Marchelle L. Suppan, D.P.M., MBA

Governor Ted Strickland has announced that **Marchelle L. Suppan, D.P.M., MBA** of Orrville has been appointed to a five-year term ending in 2013, pending Senate confirmation. Suppan is the Vice President of Medical Affairs at Dunlap Memorial Hospital and serves as Adjunct Faculty at the University of Akron, Wayne College. She is a past president of the Ohio Podiatric Medical Association and a graduate of the Ohio College of Podiatric Medicine. Suppan is an Affiliate member of the American College of Healthcare Executives; Fellow, American College of Foot and Ankle Surgeons; and Diplomate, American Board of Podiatric Surgery. She replaces David Buchan, DPM, who finished 15 years as the podiatric member in December, 2007.

Established in 1896, the Medical Board strives to protect and enhance the health and welfare of Ohio's citizens through effective regulation of more than 55,000 licensees, including: medical doctors (MDs), doctors of osteopathic medicine (DOs), doctors of podiatric medicine and surgery (DPMs), physician assistants (PAs), massage therapists (MTs), cosmetic therapists (CTs), anesthesiology assistants (AAs) and acupuncturists. The Medical Board is comprised of twelve members: nine physicians and three non-physician public members.

OPMA Legislative Update

By Dan Jones, Lobbyist

The Ohio Legislature will be keeping busy over the next few months with efforts to finalize an electric restructuring plan, pass the state's capital appropriations bill to budget for state infrastructure projects and consider a budget corrections bill to fill a budget gap that is estimated to exceed $700 million. While these "hot topics" make up the headlines in the state's daily newspapers on the activities at the Ohio Statehouse, a number of other important policy issues are of interest to OPMA and create our own headlines.

House Bill 125 – Health Care Simplification Act
After months of hearings and negotiations, House Bill 125, legislation proposed by the Ohio State Medical Association and supported by a number of health care providers including OPMA, was enacted in March 2008. The bill takes a number of critical steps forward to improving the relationship between health care providers and third party payers. Despite strong opposition from both the insurance and business lobbies in Ohio, the bill includes provisions to ensure transparency and fairness in the contracting process. The bill was signed into law by Governor Ted Strickland on March 25, 2008.

As a quick snapshot of the reforms, the bill makes these important changes:

- Ensures providers get a copy of the full fee schedule from insurers, so they know what they will be paid for their services.
- Bans the selling or renting of a provider's contract to another company unless the rental is disclosed and all of the original contract terms are honored.
- Requires all insurers to use the same credentialing form, and to credential providers in 90 days.
- Bans use of clauses in contracts that force providers to provide services at a lower rate than originally called for in contracts.

Thank you to OPMA members who answered our call to action and contacted legislators to urge their support of HB 125. Your involvement does make a difference!

House Bill 355 – Medicaid Whistleblowers
HB 355 is legislation sponsored by Rep. Jim Hughes and would create a civil right of action for Medicaid fraud schemes, and ultimately, a financial incentive for whistleblowers who allege Medicaid fraud.

OPMA and other health care providers contracting with Medicaid are opposed to the bill and are actively voicing concerns with the bill's sponsor and proponents. Opponents believe that law enforcement and the Attorney General already have the tools they need to stop Medicaid fraud, and the proposal as written compromises Medicaid provider compliance efforts and will act as an additional deterrent for attracting qualified providers in the Medicaid program.

House Bill 456 – Health Care Access
In response to field hearings held last year across the state to discuss issues related to access to quality health care, Rep. Jim Raussen has introduced HB 456. The bill includes a number of proposed policies to improve access to health care. Issues of interest to podiatrists include the following:

- Tax credits for individuals and families who purchase their own health insurance policies,
- High risk insurance pool for those Ohioans with high risk diseases or conditions that make purchasing their own insurance impossible, and;
- Requirement for every public employee benefit plan in Ohio to include coverage for chronic care management.

The bill is in early stages of legislative consideration and will be closely monitored by OPMA this spring.

Is Your Marketing Misrepresenting Your Business?

By Dr. Jimelle Rumberg, OPMA Executive Director

Sometimes questions arise regarding what can be said in advertising or on Web sites that do not mislead the public or claim superiority over another podiatric physician or product. Whether it's your intention or not, it violates the APMA Code of Ethics (2005), Advertising criteria, which cites:

> ***BE1.11 Communications with the Public***
> *The podiatrist shall ensure that communications to the public are accurate and do not convey false, untrue, deceptive, or misleading information. The podiatrist shall provide truthful and accurate representations of his/her credentials, training, experience or ability. The podiatrist shall not communicate claims of superiority that cannot be substantiated.*

Does your newspaper or yellow page advertising state that your office is the "The BEST source for Diabetic Shoes;" or "We provide the FINEST quality foot care in the area;" or "We have the area's MOST COMPREHENSIVE selection of Orthotics;" or "We have the FINEST trained podiatric physicians in the area"? **If a claim cannot be substantiated or qualified, you may not use any claim of superiority**. If there is a question in the mind of the reader as to a source that qualifies your claim, it should be removed. Qualifying claims must be substantiated without exception.

An example of a claim that is acceptable is "Voted #1 podiatric office in Peoria by *The Rockville Gazette* readers." As long as a claim of superiority can be qualified, quantified by data or substantiated, you are in compliance.

While there are many gray areas of promotion, marketing and advertising, know that OPMA is dutiful to remind you that areas of your print advertising and Web site must be in compliance with the APMA Code of Ethics.

Baby Steps... News in Brief

NPI Deadline of Note – As of May 23, physicians will be required to use only NPIs on all electronic claims submitted to Medicare and all other health care payers. That means any information discrepancies must be ironed out before this date. Though the deadlines don't apply to physicians who file only paper claims, those who send their claims to a clearinghouse that files electronically on their behalf must comply.

Ohio Medicaid Extends NPI Dual-Identifer Period – Medicaid providers who must obtain an NPI will now have until May 22, 2008 to submit their seven-digit Medicaid Legacy Provider number and their 10-digit NPI to Ohio Medicaid. Including both numbers on electronic claims will ensure claims are processed appropriately. Still haven't shared your NPI? All NPI-eligible health care providers must submit their confirmation letter from the NPI enumerator and a notation for the seven-digit Ohio Medicaid Legacy Provider number by visiting http://jfs.ohio.gov/OHP/providers/pi.stm or by faxing (614) 995-5904.

Ohio Medicaid Has New Director – John Corlett became Ohio Medicaid's new director in December. He replaced Cristal Thomas who is now serving as the executive director of the Executive Medicaid Management Administration. Prior to his new position, Corlett spent 26 years working as an advocate for Medicaid, HIV/AIDS, mental health, welfare reform, and reproductive health care. He recently served as senior fellow and director of public policy and advocacy for the Center for Community Solutions, Cleveland.

Socio-economic Afternoon Seminar Announced – OPMA will host an afternoon seminar on Saturday, August 9 on items of practice concerns for Ohio podiatric physicians. The seminar will include DME application for certification, assurity bonding, coding and more. Look for upcoming details in early summer follow the Region IV meeting regarding this upcoming event in Columbus. Mark your calendar for Saturday, August 9th.

Cutbacks May Force Docs to Stop Bone Scans – Scheduled cutbacks in Medicare physician payments may force doctors to stop offering bone density scans, despite health specialists' efforts to get osteoporosis "on the same public wavelength" as mammograms, prostate exams and other routine screenings, the South Florida Sun-Sentinel reports.

Cuts in Medicare reimbursement for dual energy x-ray absorptiometry began last year, reducing payments for a scan of the hip, pelvis and spine from $140 to $88. According to the Sun-Sentinel, based on current projections, Medicare will pay only about $50 for the same scan by 2010. According to the National Osteoporosis Foundation, most physicians and imaging centers are unable to absorb the cost and will be forced to stop offering the scans, which "could mean seniors, especially those in smaller cities, might have less access to the screenings and be less likely to get bone scans," the Sun-Sentinel reports.

Source: Diane C. Lade, South Florida Sun-Sentinel [3/17/08] via American Health Line

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OPMA Calendar of Events

This schedule is tentative and dates may change. Contact the OPMA office for more info: (614) 457-6269 or (800) 521-5318.

2008

May 15	OPMA Executive Committee
May 26	Memorial Day – Offices Closed
June 5-7	92nd Annual APMA Region IV Mid-Eastern CME Seminar
July 4	Independence Day – Offices Closed
July 24-27	APMA Annual Meeting

Handling Claims Denials

OPMA routinely gets calls regarding what to do when claims are denied for podiatry services due to allowed specialty clauses. May we suggest the following protocol for your staff? When a payer denies a claim based on "podiatry is not an allowed specialty" for the billing of a service or procedure, this is usually addressed by submitting a copy of the Ohio state practice act which can be found on the OPMA Web site under "Consumer Information." Print out a copy and send it to the medical director and appeals department. Request 1) that they modify their software to permit podiatrists to bill and be paid for the code(s) in question in accordance with the Ohio practice act and 2) that they process the claim.

Be sure to copy the letter to Dr. Rumberg at OPMA; Mary Jo Hudson, Commissioner at the Ohio Department of Insurance; the Ohio Attorney General Marc Dann; and APMA's Health Policy and Practice Department. Paper trails are vitally important, so follow through and note everyone being copied on your appeal to the carrier.



Ohio State University Medical Center
Comprehensive Wound Center

Do you have patients with wounds that won't heal?

Central Ohio's only Comprehensive Wound Center to offer you and your patients:

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- The most advanced wound healing therapies available for treatment of all types of non-healing wounds
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Ohio State's Comprehensive Wound Center offers inpatient and outpatient wound care at OSU Martha Morehouse Medical Plaza on Kenny Road and at University Hospital East.

To refer a patient or to schedule a wound consultation, please call 614-293-4811 or 1-888-340-3163.

THE OHIO STATE UNIVERSITY Medical Center

ADA – Accommodation for the Deaf

Question: A deaf patient recently contacted our office for an appointment and requested that an interpreter be present. Are we legally obligated to provide an interpreter and if so, can we pass the cost on to the patient?

Answer: According to the ADA, physicians have an obligation to provide interpreters for deaf and/or hearing-impaired patients at the time of the scheduled appointment. However, the law does not "absolutely" require that physicians provide an interpreter for every hearing-impaired person. Normally, the physician is responsible for paying for the interpreter unless it can be shown that the cost would impose an "undue burden"* on the physician.

** The "ultimate" decision maker may be a court, so it is a safer decision to pay for the cost. The cost of the interpreter may exceed the charges for that patient's care, but this alone does not constitute an "undue burden."*

Question: Is a physician required to have an interpreter for the deaf patient at every appointment?

Answer: A physician is not required to hire a qualified interpreter for every deaf patient. The ADA guidelines state that the need for an interpreter depends on the complexity of the medical matter. The ADA regulations only require that a physician's office "furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities." So long as the result of the auxiliary aids and services provide "effective" communication, physicians can choose among various alternatives. For example: an exchange of written notes may suffice for a patient with a "simple" cold, but if the condition or treatment is more complex, then an interpreter may be needed to ensure that physician and patient fully understand each other.

A physician does not have to give primary consideration to the request of the person with the hearing impairment; however, the physician should consult with the person before providing a specific auxiliary aid or service.

Question: If a sign language interpreter is required for "effective" communication, must only a certified interpreter by provided?

Answer: No. The ADA defines a sufficiently qualified interpreter to be able to interpret "effectively, accurately and impartially, both receptively and expressively, using any necessary specialized vocabulary." An individual does not have to be certified by an official licensing body to meet the above standard.

Question: If the hearing-impaired patient failed to show up to a schedule appointment, and the scheduled interpreter did show and left a bill for the services, can the cost be passed on to the patient?

Answer: No. ADA regulations prohibit charging the patient for the cost of the interpreter's time, in any situation.

Accommodation for Non-English Speaking Patients

It is not the ADA, but Title VI of the Civil Rights that requires a physician's office to provide translators for non-English speaking patients. The Civil Rights Act Title VI forbids discrimination by any program that receives money from the federal government and requires that health and social service providers give their "limited-English-proficient" patients meaningful access to their services, which may entail offering translation services. Translation services must be provided to the patients free of charge.

OPMA Goes to Washington

APMA 2008 House of Delegates – Ohio Contingent

Dr. Bruce G. Blank and Melissa Benish, Legislative Assistant for Congressman Charlie Wilson, 6th district, Ohio.

Dr. Jimelle Rumberg with Esther Oh, Legislative Assistant for Congresswoman Betty Sutton, 13th district, Ohio.

Kimberley Alton, Esq., Legislative Director for Congresswoman Stephanie Tubbs-Jones was very receptive when reviewing APMA issues on Title XIX and DMEPOS

What Makes a Great Practice Web Site?

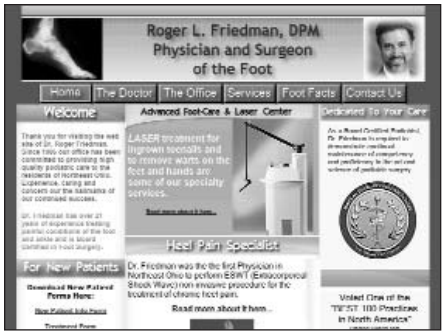
By Lauren Stewart

OPMA Administrative/Communications Assistant

A great practice Web site is only as good as its content. The content is only good if people are looking at it, right?

The first step in creating a great practice Web site is to determine its intended audience—who are you trying to reach? "The [practice] Web site is as much for your current patients as prospective patients," says OPMA member Dr. Michael Forman. His Web site, www.ilovemyfeet.com, gives prospective patients information about the doctors, staff, facility and services provided while offering current patients important phone numbers and information about procedures.

Effective marketing attracts visitors and a great practice Web site ensures repeat traffic. A clean format and easy-to-use buttons and drop-downs make certain that visitors find the information that they are looking for. If a site is too busy, confusing, or hard to navigate, people tend to give up the search.



Dr. Roger Friedman's site www.rogerfriedman.com offers patients animated demonstrations and models to help simplify complex procedures and to put a patient at ease about what is going to happen at his or her appointment. "[I] have had many patients comment that watching the animation made it much easier for them to understand how they might benefit from the procedure," he said.

Aesthetics are important as well and Dr. Friedman definitely has a unique and eye-catching format. The first page offers visitors the option to choose "Roger Friedman the Jazz Pianist" or "Roger Friedman the Podiatrist." Dr. Friedman says "I have found that it helps set [patients] at ease at their first visit as they say to me 'Oh, I see you are also…' and then we talk for a bit and establish a rapport."

Both doctors believe in presenting a welcoming image of themselves and their practices. Dr Forman says that pictures are important, especially those in which you are smiling. He jokes that his office staff thinks that he looks 'too happy' in his photo on the Web site!

Dr. Forman also stresses the need to raise awareness of your Web site. Referring doctors, patients and prospective patients can access you quickly if you make your Web address known. Dr. Forman prints, labels or stamps the Web site address on "everything that goes out of our office."

While Dr. Friedman coded and designed his Web site, there are companies that can help make the processes virtually painless. Dr. Forman used "podiatry-friendly" Officite, a company specializing in physician Web site development and medical marketing. Officite can be reached at www.officite.com or by calling (888) 817-4010. Glenn Lombardi, President of Officite, will be lecturing at the upcoming Region IV meeting in June, so you may want to attend his presentation to learn more for your office Web site.

Save the date
92nd Annual APMA Region IV Mid-Eastern CME Seminar

June 5-7, 2008

Register by mail or on-line at www.opma.org for "Podiatric Medicine's CME Event of the Year in Ohio" at the Columbus Hilton Hotel, June 5-7, 2008. This year's seminar features a cadaver workshop with Drs. G. Doc Dockery, Mary Crawford and Bradley Bakotic. The APMA PAD Lecture Series topic, "Beyond Salvage: Saving Limbs and Saving Lives" will be another added bonus for attendees. The Residency Paper Competition on Thursday afternoon will be a "wine and cheese" reception event held before a new feature, a Welcome to the Conference Chuck Wagon Barbeque. Reservations will be required for this complimentary dinner event by May 29, so don't delay if attending. The AAPPM will be presenting the Friday morning lecture series just before the "Exhibit Marketplace" and lunch (provided free by OPMA). This will be 2 hours of uninterrupted exhibitor shopping for your office and open to all REGISTERED attendees.

The Podiatric Medical Assistants have some great programming lined up (suture workshop, coding and more) with 7 hours of approved certified CME credits. The WV Podiatric Medical Association will be joining us for this year's event and for a state luncheon meeting, so we do hope that you make our neighbors feel welcome to the Buckeye State. Closing the conference will be a two-hour PICA Risk Management Lecture on "Bunionectomy Complications: A BUMP in the Road" by Michael Downey, DPM and John J. Lynch, Esq. Get a 10% discount on your next PICA renewal for attending.

Deadline for hotel reservations is by noon on May 13th. Conference early registrations must be received before May 2 for the special registration rate of $25.

In Memoriam

Edward Gellenbeck, OPMA Past President

Cincinnati lost a dedicated podiatrist when Dr. Edward Gellenbeck died at Seasons Retirement Community on January 10, 2008. Dr. Gellenbeck was a Life Member of OPMA and served as President in 1966. He was 87.

Born in Bellevue, Dr. Gellenbeck moved to Cincinnati at a young age, and decided his career during a visit with his mother to her podiatrist. He entered an accelerated year-round curriculum at the Ohio College of Podiatric Medicine, and graduated in less than five years. A week after graduation he went into the Army. Dr. Gellenbeck participated in the D-Day landing on June 6, 1944, during World War II. He was initially a grave registrar, identifying fallen soldiers, and later served as a medic throughout the Allied invasion of Europe.

Upon his return to Cincinnati he met his first wife, Harriette, a fellow podiatrist. They married and started their own practice in downtown Cincinnati. After his wife's death in 1990, Dr. Gellenbeck met Janice Witt, and they married in 1992. He sold his practice in the mid-1990s, but continued as a podiatrist in nursing homes until his retirement in 1999. The Gellenbecks moved into the Seasons Retirement Community shortly afterwards.

Besides his wife and daughter, survivors include his stepchildren, Carol Witt Bradford of Marblehead, Mass., A. Scott Witt of New Albany, Ohio, Linda Somers of Indianapolis and Lee Witt of Fremont, Ohio; a grandchild; four step grandchildren; and five step great-grandchildren. His son, Edward Gellenbeck, preceded him in death.

Sheemon A. Wolfe, DPM, OPMA Past President

OPMA Past President Dr. Sheemon A. Wolfe, 84, of Dayton, Ohio passed away unexpectedly on Friday, February 15, 2008 at Good Samaritan Hospital. A well-known and respected podiatric surgeon, Dr. Wolfe retired from practice in 2002 after 49 years. Under his tutelage, many young men and women were prepared to take their podiatric skills into hospitals and clinics all over the country. Dr. Wolfe considered the residency program he funded as his legacy to all. He loved teaching and expected others to obtain additional credentials. At the age of sixty, Dr. Wolfe obtained his Board Certification in Surgery. He was a fellow of the American College of Foot and Ankle Surgeons and a Diplomat of the American Board of Podiatric Surgery.

A life-long member of the American Podiatric Medical Association, Dr. Wolfe became president of the Ohio Podiatric Medical Association in 1980. He was named Adjunct Clinical Professor in 1986 and Contributing Advisor of the American Council on Podiatric Medical Education. After retirement, he held Emeritus status at Greene Memorials, Good Samaritan, Miami Valley and Grandview Hospitals. Dr. Wolfe was a member of Beth Abraham Synagogue and Men's Club, US Army Veteran of WWII serving in Germany and a member of the Jewish War Veterans.

Dr Wolfe is survived by his wife of 47 years, Rachell; sisters and brother-in-law, Jean Walzer of Thailand, Drs. Madlyn and Tom Stein of San Francisco; and several nieces and nephews. He was preceded in death by his daughter, Andrea in 1992.

Joseph M. Griffith, Jr., DPM

It is with sadness that we report the passing of Joseph M. Griffith, Jr., DPM, age 80, formerly of Upper Arlington, and Fort Myers, Florida, returned to Columbus and resided at the Trillium. Born June 21, 1927, died February 1, 2008, at Riverside Methodist Hospital. He was preceded in death by his wife of 49 years, Norene Lynch Griffith, and his parents Dr. and Mrs. Joseph M. Griffith. Survived by three daughters, Susan Jones of Dublin, Sharon (Steve) Mintos of Granville and Cindy Griffith of Hilliard; sister, Mary Pat Wallace of Upper Arlington. Also seven grandchildren, Tyler, Trevor (Kelly) and

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DMEPOS and Competitive Bidding

Nearly everyone was taken by surprise in 2003 when, during a closed conference between the House and Senate, a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) competitive acquisition provision was included in the *Medicare Modernization Act (MMA).* Congressional intent for the program was to clamp down on fraud and abuse related primarily to power wheelchairs and other costly items of DMEPOS. Its full implication was not understood until the final bill was published and examined, and the APMA realized the program created a number of issues for podiatric medicine.

The DMEPOS statutory provision failed to recognize podiatrists as physicians authorized to perform a patient examination required to prescribe DMEPOS. But it still required all physicians—including podiatrists—to participate in competitive bidding and to be accredited to supply any DMEPOS as part of patient care.

APMA has subsequently focused efforts related to this program on ensuring that podiatric physicians are treated equitably with other physicians, and on mitigating or repealing other adverse effects on podiatric practices. While having met with success on some fronts and made positive steps on others, the association continues to actively lobby both CMS and Congress about ongoing issues related to DMEPOS.

What needs to be done? APMA expects Congress to pass yet another Medicare bill early in 2008 because most of the provisions in the Medicare bill enacted on December 29, including the 0.5 percent fee increase, will expire June 30. Congressional action to address Medicare will provide APMA with another opportunity this year to convince Congress to correct the DME physician definition and exempt physicians from the accreditation requirement. Authority to resolve both of these issues resides with Congress, not with CMS.

Authority to resolve the surety bond issue, however, does reside with CMS, which is reviewing comments on the proposed rule. APMA is not likely to know CMS' decision on this until the final rule is released later this year.

APMA members are urged to continue using the APMA e-Advocacy Web site to press for passage of the bills in 2008, and to write, fax, and call Congress even if they have done so in the past year on any of APMA's issues. Members can log on to http://www.apma.org/eadvocacy for information and updates, to see who represents them in Congress, to learn which Representatives and Senators have cosponsored bills, and to send a message to Congress.

Podiatry Redefined in Texas

The Texas Court of Appeals, Third District at Austin issued its opinion March 14 in the Texas Podiatric Medical Association (TPMA) scope of practice litigation. Unfortunately, the court ruled that the Texas State Board of Podiatric Medical Examiners exceeded its authority when it ruled to define the word "foot" because "the rule authorizes treatment of body features that are above the ankle." Accordingly, the court reversed the district court's decision that upheld the rule and remanded the case to the district court for proceedings consistent with the court's opinion.

While APMA is disappointed with the court's opinion and believe it is incorrect, TPMA has yet to exhaust all legal remedies. TPMA will file a motion for rehearing with the Court of Appeals, and, if that is unsuccessful, appeal the case to Texas Supreme Court.

It is important to note that the rule defining the "foot" (which includes the ankle) remains as the podiatric physicians' legal scope of practice in Texas while the motion for rehearing and appeal are pending until a new rule is adopted or there is a final determination by the Texas Supreme Court.

Meanwhile, APMA continues to work diligently with component societies and affiliated/related organizations to implement strategies relating to Vision 2015. Rest assured that APMA has discussed the situation with TPMA. TPMA will continue to update APMA so that we may be readily mobilized to assist TPMA per its request. Over the years, TPMA leadership and its members have worked diligently to secure a positive outcome on the issue concerning Texas podiatric scope of practice. The ruling by the appellate court is neither a final pronouncement nor does it foreclose avenues to protect the interest of the podiatric medical community. TPMA has strong leadership, dedicated staff, and committed members to see the issue through a positive outcome for Texas podiatric physicians and for the profession. Please give TPMA and its member's time to deliberate for any subsequent course of action.

INSURANCE continued from page 1

ance and fairness in the contracting process between physicians and health insurers. The bill, which takes effect in 90 days, includes provisions that would:

- Ensure physicians get a copy of the full fee schedule from insurers, so they know what they will be paid for their services.
- Ban the selling or renting of a physician's contract to another company unless the rental is disclosed and all of the original contract terms are honored.
- Require all insurers to use the same physician credentialing form, and to credential physicians in 90 days.
- Ban use of clauses in contracts that force doctors to provide services at a lower rate than originally called for in their contract.

Thanks to the efforts of an OPMA grass roots initiative via the listserv, our phone calls and emails made the difference in the eleventh hour in the Senate. Thanks to each member who took the time to contact their legislators to advance this legislation.

What Does OPPAC Do For You?

Like it or not, politics have a major impact on your practice in Ohio. For example, your license to practice is codified in Ohio Revised Code via the legislature, with professional oversight provided by the State Medical Board of Ohio. Many statutes and regulations which govern your practice operations are determined in Columbus every week.

The Ohio Podiatric Political Action Committee (OPPAC) is a non-profit, non-politically aligned collective managed by DPM's for the betterment of podiatry in Ohio. OPPAC educates elected and appointed government officials about the critical role podiatric medicine plays in Ohio's health care system. OPPAC assists legislators and candidates for public office who appreciate and support the podiatric medical profession.

OPPAC opens doors for dealing with legislative and regulatory issues of interest or concern to OPMA: licensure, hospital privileges, scope of practice, insurance, professional discipline and practice regulations. Most recently, we were successful in getting a Rule change withdrawn by the Ohio Board of Dietitians. This changed would have restricted your right as a podiatric physician to counsel patients on their diet and mandated you to refer all patients to a licensed dietitian regarding nutrition concerns. Can you imagine not being able to discuss the role of sodium to a patient with edema, or dietary restrictions for patients with gout? What about poor nutritional habits with diabetic patients whose wound care treatment or management may be compromised?

Your OPPAC contribution will help ensure that our collective DPM voice is heard on Capitol Square. When you consider that all it takes is the single stroke of a pen to write podiatry into or out-of the law, isn't it time you open your check book and write a check to OPPAC?

Please send your personal contribution to OPPAC at 5310 McKitrick Blvd, Columbus, OH 43235. We **cannot** accept corporate checks or corporate credit cards for OPPAC. A $300 contribution is suggested. To use your Visa, Mastercard or AMEX, call toll free 1-800-521-5318. Don't delay your support another day. Help us help you!

OPPAC Contributors: Advancing Podiatry's Advocacy

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Jimelle Rumberg, Ph.D.
Kevin Sneider, DPM
Peter Wiggin, DPM
David Zink, DPM

It is with great appreciation that we thank all of you who contributed.

MEMORIAM continued on page 12

Courtney Jones; Anthony, Michael, Alexander and Sam Mintos; and a great grandson, Nathan. He was a veteran of the United States Navy.

Dr. Griffith practiced for 38 years in North Columbus and Upper Arlington. He graduated from North High School class of 1945, attended The Ohio State University and graduated from The Ohio College of Podiatric Medicine in 1952. He was a member of the National Association of Podiatrists, a Life Member of the Ohio Podiatric Medical Association, The Central Ohio Academy of Podiatric Medicine, and the American College of Foot Surgeons.

He was a member of the Legends Golf and Country Club in Fort Myers, Florida and a former member of Worthington Hills Country Club. He was a member of Triangle Masonic Lodge, Scottish Rite, Aladdin Shrine, and Agonis Club. He was also a member of Old North High Club.

Glenn Meyer, DPM

Dr. Glenn Meyer of Montgomery, husband of Shirlaine (nee Bellamah) Meyer. Father of Robert (Amie) Meyer, Christopher (Suzanne) Meyer and Mary Ann (Brian) Spurling. Grandfather of Makenzie, Benjamin and Matthew. Son of Helen Meyer. Brother of Jody and Peggy Meyer, and Dr. Mark Meyer.

Dr. Meyer died from liver cancer on November 30, 2007 at the age of 59 at the Bethesda North Hospital. Mass of Christian Burial was on December 3 at The Community of the Good Shepherd. Memorial contributions suggested to the Medical Volunteers of Cincinnati c/o Brian Tippett 10304 Peachtree Lane, Cincinnati, OH 45242.

Joseph Jacob Shuchat, DPM

Dr. Joseph Jacob Shuchat passed away on April 15, 2006, at the age of 89. Dr. Shuchat was born June 24, 1916. He graduated from the Ohio College of Chiropody (now the OCPM) with the Class of 1937 and joined the Ohio Chiropody Association (now the OPMA) that same year. His practice was interrupted in 1940 when he was drafted into the U.S. Army. He served in the Army for four years and returned to practice podiatry in Piqua, Ohio. Dr. Shuchat, Chiropodist & Foot Orthopedist, ran a private practice "specializing in the treatment of foot ailments." Dr. Shuchat became a life member of the American Podiatric Medical Association in 1994. He was a past president of the Midwest and Central Academies in Ohio. His wife, Sarah, and only child, Francine, survive him. He was active in the Elks, the Masons and with his country club.

Visit www.opma.org to register for the 2008 Region IV CME Seminar June 5-7, 2008 at the Columbus Hilton Hotel

Secrets of Success: Staying on Schedule

By SOS Healthcare Management Solutions, LLC

When we are called into a practice to analyze office flow, investigate why the schedule gets backed up and pinpoint the suspect bottlenecks, I start by asking the same question to both doctors and staff, "In your opinion, where do you see the problem to be?" If you were to guess that the doctors blame the staff and vice-versa, you'd be right. The truth is keeping your office on schedule requires a team effort. Backups are not generally a result of just one thing or one person, so stop pointing fingers and let's concentrate on implementing some proven strategies for improvement.

Start on Time: Did you know that starting late is the single biggest cause of running behind? If your first patient is scheduled at 8am, then, doctors, you need to arrive before then, allow yourself the time to do what you have to do before beginning your day and be ready before that patient comes in. By the same token, if the staff does not have that patient checked in and set up in a treatment room by 8am (or sooner), the schedule is already compromised.

Scheduling Protocol: Staff should have adequate policies and protocols to follow that allow them to properly manage the schedule. That means not scheduling a new patient for 15 minutes if it really takes 30; or a post operative redress for 15 min, if it really only takes you five. Scheduling should be done according to facts, not guesswork. Take your 5 or 10 most common procedures and assign a time to each one based on monitoring the average time you spend with each one; then schedule accordingly.

Two fer one: "Doctor, can you also look at little Jimmy's foot while I have him here with me?" This common request from a patient who's dragged their son with them, hoping to get both visits done together (in an effort to save time or money) needs to be properly handled, or it's a surefire way to throw your day off. After a brief dialogue about little Jimmy's problem (while you are working!) and determining it is not an emergency situation, the best response you can give your patient is, "In order for me to give little Jimmy the proper attention he deserves, I suggest you ask Carol at the reception desk to schedule a separate appointment for him." If your response is such that the patient feels it is in their best interest, they will cooperate.

Streamline your check-in process: Insist that your new patients present with their patient registration paperwork completed. The national benchmark for completing new patient paperwork is 14 minutes. If your form is very comprehensive, it may actually take longer than that. So, for example, a practice that sees 4 new patients a day and can shave 14 minutes or more off each one of those visits, can gain almost another whole hour in their day. Of course, the most efficient way to accomplish this is to have your own Web site where they can download the form. But if not, mail it to them or tell them their "appointment time" is 15 minutes earlier than what is actually recorded in the schedule, so that this time is actually "built in" to your schedule.

Late Arrivals and No Shows: It's not unrealistic to expect that there will be times when a patient legitimately arrives late for an appointment—maybe they got lost, hung up in traffic, had an emergency that detained them, and in all possible cases, we try to be fair and accommodating. However, it's important that your staff does not give up the control of these types of situations to your patients to the point that the patient takes advantage of them. For those patients who make a habit of arriving late for each appointment, staff needs to professionally address their tardiness and again, present it in such a way that it is in their best interest, not yours that they are rescheduled. And if such a policy is put in place, then doctors, it's important that you support your staff's actions and not contradict them. Of course, if the schedule permits, you can offer them the option of waiting, but remember, by bending over backwards to fit these types of patients in every time they come in late, you are actually **training** them to repeat this unacceptable behavior, which is not fair to your other patients.

You can't monitor it, if you can't measure it: By conducting regular time and motion studies, you can pinpoint exactly when patients are waiting the longest during an encounter and where you can reduce or eliminate wasted time. For a more successful study, get your patients involved. Give them a worksheet and ask them to record specific times during their progression through the office (when they entered, their scheduled visit, when they were called into the treatment room, what time the doctor presented, how long they spent with the doctor and how long it took to be discharged.) If they know they can play a small role in helping to make their future visits more time-efficient, they are happy and willing to be a part of that process.

In a survey conducted by Consumer Reports, the number one common complaint patients have about doctors is that they are kept waiting 30 minutes or longer, and in fact, according to an NCR survey, consumers list it as the third most annoying wait, comparing it to waiting at the Division of Motor Vehicles. Ouch! Patients expect doctors encounter emergencies every now and then, but it's not reasonable to expect them to wait…and wait…and wait. One thing is certain—if you do nothing about it, nothing will ever change. The choice is yours.

– SOS Healthcare Management Principals are John Guiliana, DPM, MS, Lynn Homisak, PRT and Jason Kraus. All are Fellows of the American Academy of Podiatric Practice Management where Lynn serves as Vice-President and Jason sits on the Board of Trustees. Dr. Guiliana holds a Masters in Healthcare Management, Ms. Homisak, a Certificate in Human Resource Studies and Mr. Kraus has held executive management positions in the healthcare industry for over 25 years.

Appealing Denials

Should you or should you not?

By Louise R. Hill

It's time to put another rumor to rest in 2008. This particular rumor has been circulating for some time among physician practices. May we finally let it rest in peace. What is this rumor? It is the rumor that says if you appeal a denial that you will be targeted for an audit or a delay in paying your claims.

One study says that as many as 50% of denied claims are never resubmitted or appealed. Year after year medical providers leave money on the table of insurance companies. This helps the health insurance companies remain profitable while bankrupting the cash flow of your practice. Appealing denied claims does not set you up for audits. In fact, your chances of success in an appeal are better than you think. Also the state of Ohio has prompt pay laws that insurers much adhere to so they cannot delay paying your claims without being subject to financial penalties. In the good old days maybe you could afford to leave money on the table, but not today. With low reimbursements, high malpractice, high staff turnover and expenses rising, practices need every cent of their money.

Most denials fall within two categories: claim level denials and service level denials. Claim level denials involve the denial of the entire claim. Some of the most common are duplicate claim, patient not identified as our insured, date of death precedes date of service). Service level denials are claims where a portion of the claim is denied. Reasons can range from modifier invalid for procedure code to invalid diagnosis. Most service level denials are due to inadequate training of staff on the latest billing and coding regulations.

The other problem is that although some practices have no problem appealing denials, they don't know where to start. The EOB's that they receive are often coded with denial codes that don't make sense even after you have read the explanation for it at the bottom of the page. Precious time must still be spent calling the insurance company and asking them to translate the meaning of the code in plain English. Even then some of the reps can't really explain it either, or their explanations confuse us even further. (My favorite is please refer to our Web site and after doing so, I find that the information is not there). So let's decode a few of the most common denials and how to appeal them.

These are non-covered services because this is not deemed a medical necessity by the payer.

Medicare uses this code a lot. Other payers state the wording slightly differently. The good news is that you don't need to appeal this denial with massive notes showing how necessary the service was for the patient. The code simply means that you didn't use one of the diagnoses on their approved list for this CPT code. Sometimes providers are one digit off from the correct code. Go to their Web site and choose one of the diagnoses that they have approved on their list.

Claim/service denied/reduced because this procedure/service is not paid separately or is included in the surgical fee. What they really mean is that you have chosen two procedure codes that are on the CCI list that are not compatible. Most insurance companies utilize the CCI edits and have them built into their computer logic.

What are CCI edits? CCI or NCCI is the national correct coding initiative developed by CMS to create standard coding rules and make sure claims are not improperly paid. Every office should have a copy of these edits and you can download one free at www.cms.hhs.gov. The edits are listed by service categories because there are so many of them. They will show which codes when billed together will be paid and which will not be paid. I recommend doing a self audit by taking your coding and comparing it to the tables. This may help you identify potentially thousands in lost earned income.

Service pending or not considered. Requested information not received. Unfortunately, you will have to call the insurance company on this one to find out what information they are talking about. It could be operative notes from you or a questionnaire asking about other insurance coverage or dependent eligibility that they sent to the patient. If they are requesting information from the patient, don't assume that the patient has received notification and sent it in. Call the patient as a friendly reminder to get that information in to their insurance company.

Inevitably, your practice will want to prevent denials before they happen. This would include creating a process to avoid claim denials and a claims recovery process to address claims that deny. An ongoing process for monitoring trends in denials would be very beneficial. Remember, addressing denied claims is important and necessary to your bottom line.

– Louise R. Hill is CEO of Bout Time Medical Billing Service. Her expertise spans 24 years in the medical insurance claims industry. She can be contacted at Louise0623@yahoo.com or 216-906-3698.

Upcoming OPMA Educational Offerings

- **GXMO Certification, Re-certification and Digital Training Classes**—TBA, Summer
- **Socio-economic Seminar and DME Accreditation**—Aug 9, Columbus

State Medical Board Defines Scope of Podiatric Medicine in Ohio

The OPMA has received several inquiries regarding scope of practice for podiatry pertaining to wound care with regards to the lower leg. Specifically, does the scope of practice include the treatment of wounds of the lower extremity from below the knee distally or only the ankle distally.

At the April 9, 2008 meeting, the State Medical Board of Ohio approved the following response:

The scope of practice of podiatry in Ohio is defined in Section 4731.51, Ohio Revised Code, to include the following:

- *The medical, mechanical, and surgical treatment of ailments of the foot, the muscles and tendons of the leg governing the functions of the foot;*
- *The use of such preparations, medicines, and drugs as may be necessary for the treatment of such ailments; and*
- *Treatment of local manifestations of systemic diseases as they appear in the hand and foot, but the patient must be concurrently referred to a medical or osteopathic physician for treatment of the systemic disease itself.*

Podiatric medical education and training encompasses the anatomy of the leg and the muscles and tendons of the leg governing the functions of the foot. Podiatric physicians play a significant role in the delivery of medical services for the treatment of foot and ankle pathologies, especially for diabetic wound care. The required expertise to provide wound care is not dependent upon the site or etiology of the wound as the same knowledge and skills are required whether the site is above or below the ankle and no matter the etiology. **For this reason, it is clear that the medical services a podiatric physician may perform include, as medically appropriate, the treatment of foot and ankle pathologies through wound care services applied to wounds that are located below the knee distally.**

On a related matter, you may find it helpful to know that the Medical Board has determined that while a podiatric physician may use hyperbaric oxygen treatment in wound care, **a podiatric physician may not supervise the rendering of hyperbaric oxygen therapy**. Accordingly, it is within the scope of practice of an Ohio podiatric physician to treat wounds from below the knee distally when the procedure is medically appropriate, except that the podiatric physician may not supervise the rendering of hyperbaric oxygen therapy when it is utilized for wound care. As with all medical procedures, the podiatric physician must perform the procedure in conformance with the minimal standard of care of similar practitioners under the same or similar circumstance.

It should be noted that hyperbaric oxygen therapy is provided in a chamber in which the entire patient's body is immersed in oxygen. As podiatrists are authorized to provide medical, mechanical and surgical treatments to the foot, including the ankle, and the muscle and tendons of the leg governing the functions of the foot, it is appropriate that a podiatric physician utilize hyperbaric therapy in the treatment of lower extremity wounds. The hyperbaric chamber creates possible medical complications that are beyond the scope of practice of podiatric medicine and surgery. For example, there is an increased risk of complications involving the otologic, pulmonary, and central nervous systems. Accordingly, a podiatrist may not supervise the rendering of hyperbaric oxygen therapy.

This analysis is consistent with the future availability of certification in Undersea and Hyperbaric Medicine, which will be limited to allopathic and osteopathic physicians. The certification will be a subspecialty recognized by the American Board of Emergency Medicine and the American Board of Preventive Medicine. If you have additional questions concerning the regulation of podiatric medicine, please contact Sallie Debolt, Executive Staff Attorney at 614-644-7021.

CMS Delays Changes to Anti-Markup Provisions for Some Diagnostic Tests Until 2009

CMS is delaying some parts of the revised anti-markup provisions for certain diagnostic tests until 2009 due to public comments indicating that some aspects are unclear and could disrupt patient services, according to a final rule published in the Jan. 3 Federal Register. The amended anti-markup provisions would apply to the technical and professional components of diagnostic tests that are billed for by a physician or supplier who ordered the tests. When the "diagnostic test is either purchased from an outside supplier or performed at a site other than the office of the billing physician or other supplier, the payment to the billing physician…for the technical component or professional component of the diagnostic test may not exceed the lowest of the following amounts": the performing supplier's net charge to the billing physician or other supplier, the billing physician or other supplier's actual charge, or the fee-schedule amount for the test that would be allowed if the performing supplier billed directly, CMS says.

The confusion comes from the definition of "office of the billing physician or other supplier," CMS says. This is the medical office space where the majority of care is provided. CMS says physician groups who submitted comments alleged that "in situations in which they are subject to the anti-markup provisions and are limited to billing Medicare for the amount of the net charge imposed by the performing supplier, because they will not be able to realize a profit and will not be able to recoup their overhead costs, they will not be able to continue to provide diagnostic testing services to the same extent that they are currently providing such services."

Source: *Report on Medicare Compliance* [1/7/08]

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